Long Term Care Highlights

North Dakota Department of Health
Division of Health Facilities

June 2004

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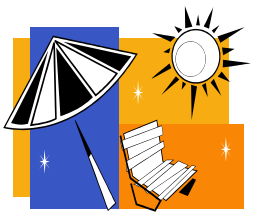

Special points of Interest:

- Learn what seven components are to be included in development of your policies and procedures regarding abuse of residents.
- Federal regulations require a clinical indication for the use of a hypnotic (sleeping pill).
- The nurse needs to see herself as a care role model, a gerontological nurse, a leader and a care team builder.
- CMS has posted the new RAI User's Manual on its website.

Seven Key Components of Abuse Policies and Procedures

By Judith Johnson, RN

The Code of Federal Regulations at 483.13 (b) states; "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. 483.13 (c) states; "The facility must develop and implement written polices and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property."

In the fall of 2001, the Center for Medicare & Medicaid Services identified seven key components that a long term care facility must include in policies that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. The seven key components include screening, training, prevention, identification, investigation, protection and reporting/response. For two years, surveyors reviewed policies and procedures during each standard recertification survey to determine if the seven key components were included.

During 2003, the North Dakota Department of Health cited 23 deficiencies for resident-to-resident abuse and failure to investigate all injuries of unknown origin to rule out possible abuse or neglect. The resident-to-resident abuse included verbal, sexual, physical and mental abuse.

Residents who are abusive to other residents require assessment, monitoring and a care plan to address the abusive behavior, and residents who are abused require protection from further injury or mental anguish. In addition, the surveyor will request evidence that the facility identified the problem, took corrective action and completed follow-up monitoring.

(continued)

Abuse (cont.)

A protocol to investigate injuries of unknown origin such as skin tears, bruises and abrasions is a minimum standard. An investigation includes the circumstances surrounding the injury of unknown origin and the action taken. The purpose of the investigation is to determine if the injury of unknown origin was simply coincidence.

The purpose of developing and implementing policies and procedures that include the seven key components is to assist the facility in establishing a system for the prevention and investigation of incidents that have the potential to be incidents of mistreatment, neglect and abuse of residents and misappropriation of resident property.

Resident Rights and Hypnotic Usage

By Carolyn Desper, BNSc, RN

What about the resident's rights when it comes to the use of a sleeping pill (hypnotic)?

This question is often asked by a facility concerning the use of a hypnotic by a resident, especially a cognitively intact resident. Federal regulation requires a clinical indication for the use of a hypnotic. Reasons such as "the resident wanted it," or "the doctor wrote an order for it," do not meet the intent of the regulation.

In the guidance to surveyors, at F 329, the following information is given:

"Drugs used for sleep induction should only be used if:

- Evidence exists that other possible reasons for insomnia (e.g., depression, pain, noise, light, caffeine) have been ruled out.

- The use of a drug to induce sleep results in the maintenance or improvement of the resident's functional status.

- Daily use of the drug is fewer than 10 continuous days unless an attempt at a gradual dose reduction is unsuccessful.

- The dose of the drug is equal to or less than the following listed doses unless higher doses (as evidenced by the resident response and/or the resident's clinical record) are necessary for maintenance or improvement in the resident's functional status.

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Resident Rights and Hypnotic Usage (cont.)

HYPNOTIC NOT MAXIMUM DOSES

GENERIC	BRAND	DOSE BY MOUTH
Temazepam	(Restoril)	7.5 mg
Triazolam	(Halcion)	0.125 mg
Lorazepam	(Ativan)	1 mg
Oxazepam	(Serax)	15 mg
Alprazolam	(Xanax)	0.25 mg
Estazolam	(ProSom)	0.5 mg
Diphenhydramine	(Benadryl)	25 mg
Hydroxyzine	(Atarax, Vistaril)	50 mg
Chloral Hydrate	(Many Brands)	500 mg
Zolpidem	(Ambien)	5 mg

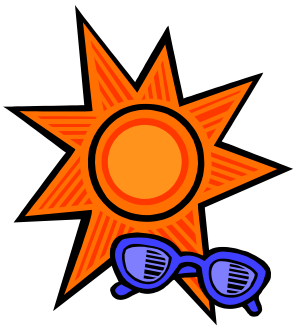
Notes: 1. Diminished sleep in the elderly is not necessarily pathological.

2. The doses listed are doses for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence to show why it was necessary for the maintenance or improvement of the resident's functional status.

3. Diphenhydramine, hydroxyzine and chloral hydrate are not necessarily drugs of choice for sleep disorders. They are listed here only in the event of their potential use.

4. For drugs in this category, a gradual dose reduction should be attempted at least three times within six months before one can conclude that a gradual dose reduction is clinically contraindicated."

So, what does all this mean for the facility? It means hypnotics are looked at just like any other antipsychotic medication.



Examples of documentation supporting the use of hypnotic medications may include:

- A physician's progress note indicating the medication is being used appropriately, including the reason the physician considers the use appropriate and its use is in the resident's best interest.
- Thorough documentation of signs/symptoms necessitating the use of the medication including the resident's response to any alternatives attempted before using medication.
- Documentation confirming attempts at dosage reduction, including the resident's response to the dose reduction attempts.
- Specific documentation as to why the resident may require a dose outside the guidelines.

Federal requirements ask for a planned methodical approach to the initiation of a hypnotic. But what happens when a resident, who has shown no signs of sleep disturbance, returns from a medical appointment with a physician progress note that reads "complains of not sleeping, will give sleeping pill"? Now what?

As a facility you have the responsibility to make sure the resident is getting the services needed. Educate the resident and document the specifics of the education provided. Include as much information as possible, just as you would in initiating an antipsychotic. The process will be different, but the guidance does not change.

Residents do have the right to have a sleeping pill. Residents also have the right to be well informed and have the knowledge to make an informed decision. The facility needs to make every effort to ensure the resident has the information needed to make safe choices.

References:

State Operations Manual: Appendix P. Survey Procedures for Long Term Care Facilities, pages 118 and 119.

L.E.A.P.
A Plan for Staff Retention

By Laura Hiebert, MS, LRD

Nursing staff members play an important role in the day-to-day operation of their long term care facilities. Unfortunately, many of these vital employees are growing frustrated and increasingly dissatisfied by their chosen profession.

Long "to-do" lists and staff shortages leave employees feeling overwhelmed and powerless to change their situation. This dissatisfaction is driving a mass exodus of nursing staff from the long term care industry.

The Paraprofessional Healthcare Institute estimates that one million new certified nursing assistants will be needed to fill long term care vacancies and new positions by the year 2010.[1] Projections for nurses are similar.

It is clear that innovative solutions will be required to meet the demands for long term care staffing in the future. One organization that has risen to this challenge is Mather LifeWays in Evanston, Ill.

Working in conjunction with Life Services Network (the Illinois affiliate of the American Association of Homes and Services for the Aging), Mather LifeWays has developed the LEAP program, a proactive program aimed at increasing staff retention.

Learn Empower Achieve Produce

The objectives of the LEAP program are as follows:
Learning to use tools and resources for quality long term care;
Empowering caring and competence in self and others;
Achieving commitment to work teams and the organization; and
Producing opportunities for growth and development.[1]

"LEAP shifts the model of nursing care from a task-oriented, medical model to one that emphasizes four essential roles of the nurse in long term care. The nurse needs to see herself as a care role model, a gerontological nurse, a leader and a care team builder."[2]

Facilities who wish to participate in the LEAP program begin by completing the "Organizational Learning Readiness Survey." This survey service is provided to facilities at no charge and helps to identify if your organization would benefit from participation in the LEAP program.

After the survey, facilities send two to three staff members to a train-the-trainer workshop held at Mather LifeWays in Evanston, Ill. (With a minimum of 15 participants, Mather LifeWays will move the training to your home state, decreasing the costs of travel and lodging.)

Participating staff members are supplied with the materials they will need to return to their facilities and train their fellow staff members. Training materials are divided into two modules: (1) "Essential Roles of the Nurse in the LTC Settings" for RNs and LPNs; and (2) "Growing the Heart of Care: Career development for CNAs."

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L.E.A.P.—A Plan for Staff Retention (cont).

Mather LifeWays' own nursing care center found its nursing turnover rate decreased from 44 percent to 16.7 percent, and CNA turnover decreased from 76 percent to 15 percent after participating in the LEAP program. In addition, participation in the LEAP program seems to correlate with fewer health deficiencies cited during facilities' federal surveys.[2]

Estimates of the costs of hiring new staff range from $3,000 to $7,500 per person. The ability to retain staff members currently holding positions in your facility leads to significant savings.

To learn more about the LEAP program, contact:

Marilyn Noettl, LEAP Project Coordinator
Mather LifeWays
1603 Orrington Avenue, Suite 1800
Evanston, IL 60201
Phone: 847.492.6817
Fax: 847.492.6789
e-mail: mnoettl@matherlifeways.com

[1] Hollinger-Smith, Linda, "It Takes a Village to Retain Quality Nursing Staff, Nursing Homes/Long Term Care Management, May 2003, Vol. 52, No. 5.
[2] LEAP Fact Sheet, March 2004.

North Dakota Department of Health
Division of Health Facilities
600 E. Boulevard Ave., Dept. 301
Bismarck, N.D. 58505-0200
Phone: 701.328.2352
Fax: 701.328.1890
Website: www.health.state.nd.us

Terry L. Dwelle, M.D., MPHTM
State Health Officer
Darleen Bartz, Chief,
Health Resources Section
Bruce Pritschet, Director
Division of Health Facilities

MDS Updates

By Patricia Rotenberger,
MDS Coordinator

On April 26, 2004, CMS posted the new RAI User's Manual updates on its website (www.cms.hhs.gov/medicaid/mds20/man.form.asp). Most of the revisions were deletions or additions of words or phrases to clarify specific coding areas or scenarios and to correct spelling errors in the book.

In section M (skin conditions) the words "due to any cause" and "of any type" were removed. Hopefully, this will help MDS coordinators when they have to code in this section.

As a reminder, if you are coding a resident for being on a scheduled toileting program or a turning/repositioning program, CMS defines "program" as a "specific approach that is organized, planned, documented, monitored and evaluated."

CMS strives for improving the accuracy of the MDS data and addressing provider education needs. As part of this commitment, CMS has contracted with Computer Sciences Corporation to implement the DAVE (Data Assessment and Verification) Program. This program has expanded nationwide. At any time, your facility could be contacted to provide medical records for the DAVE contractors to review. They will be determining if the assessments completed by the facility are supported by documentation in the medical record.

If you have any questions, please call Pat Rotenberger at 701.328.2364